DOCUMENT RESUME

ED 033 480 EA 002 641

TITLE	Teamwork in School Health; Guidelines for School-Community Coordination. A Report of the National Conference on Coordination of the School Health Program.
INSTITUTION	American Association for Health, Physical Education and Recreation, Washington, D.C.
Pub Date	62
Note	36p.
Available from	American Association for Health, Physical Education and Recreation, 1201 Sixteenth St., N.W., Washington, D.C. 20036 ($.75)
EDRS Price	EDRS Price MF-$0.25 HC Not Available from EDRS.
Descriptors	Committees, Guidelines, *Health Education, *Health Programs, Leadership Qualities, Leadership Responsibility, Parent Child Relationship, *Program Coordination, Program Evaluation, *School Community Cooperation, School Community Relationship, *School Health Services

Abstract

An effective school health program requires optimum coordination of the efforts of parental, professional, governmental, voluntary, religious, commercial, civic, and service groups in the community. Common methods for achieving coordination, which vary in effectiveness depending upon available personnel and community needs, include: (1) informal procedures, (2) an ad-hoc problem-solving group, (3) a continuing committee or council, (4) a specialized advisory committee, and (5) combinations or adaptations of the above. Effective coordination also requires leadership which exhibits an understanding of the school health program, appreciation of program goals, skill in working with people, and a discriminating use of authority. The coordinating group must also develop procedures to continually evaluate the efforts and effectiveness of the program. A selected bibliography containing 82 references from the literature pertaining to teamwork in school-community health programs is included. (JH)

TEAMWORK IN SCHOOL HEALTH

A Report of the

National Conference on Coordination

of the School Health Program

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

Conference Sponsors

National Health Council

American Association for Health, Physical Education, and Recreation
(A Department of the National Education Association)

Conference Steering Committee

Crescent Bride
William H. Creswell, Jr.
Roy L. Davis
Donald A. Dukelow, M.D.
Marian V. Hamburg
Fred V. Hein
Charlotte Leach
Levitte Mendel
Johnny J. Miller
Elsa Schneider

Editing Committee

William H. Creswell, Jr.
Roy L. Davis
Fred V. Hein
Levitte Mendel

Second Printing 1963
AMERICAN ASSOCIATION FOR HEALTH, PHYSICAL EDUCATION, AND RECREATION
A Department of the National Education Association
1201 16th Street, N.W., Washington, D.C. 20036

Library of Congress Catalog Card No. 62-17474 **PRICE: 75¢**

CONTENTS

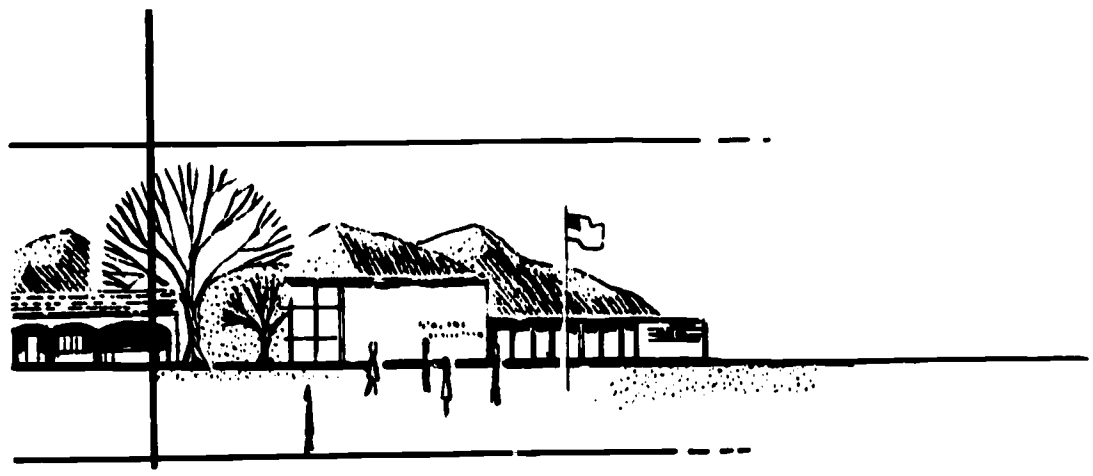
FOREWORD

School people, community health personnel, and parents have long been interested in developing better ways of working together to insure the best possible programs in both health and education for children and youth. Statements of guiding principles for cooperation have been developed by various organizations, and professional literature contains many articles describing how groups have organized to achieve common goals.

However, for some time a single publication has been needed to tie together these opinions and recommendations and to reflect the thinking of professional, official, and voluntary leaders in both the education and health fields. To develop this publication, a Conference on Coordination of the School Health Program was called by the National Health Council and the American Association for Health, Physical Education, and Recreation in October 1960 in Washington. Conference participants are listed at the end of this report.

The Conference's Steering Committee and the conferees proceeded on the assumption that it would be helpful to devise a statement of guiding principles concerning school-community relationships as these apply to the health of school-age children. A number of practical plans and procedures for coordination were developed and are outlined and described in this report. Suggestions are also made relating to leadership for coordination, the basic principles involved, and evaluation and implementation of coordination procedures. The material, it is hoped, will prove useful to school staffs, parents, health department personnel, members of the health professions, voluntary workers, and others who are seeking ways for better coordination of school health programs. Application and adaptation will, of course, vary with communities.

Conclusions of the Conference reflect the consensus of a number of disciplines and do not necessarily constitute official viewpoints or policies.



WHY COORDINATION?

The fact that boys and girls are required to attend school for several hours a day presents a unique opportunity for health promotion, provided instruction is offered under skilled teachers in a climate conducive to learning about health. Positive health attitudes and practices may be further strengthened through school health service activities that are offered in a setting which exemplifies healthful living.

The school's responsibility for health education and health promotion rests upon four principal premises:

1. The obligation of the school to aid in maintaining the pupil's optimum fitness to learn;
2. The obligation of the school to maintain conditions that promote healthful living while pupils are under school jurisdiction;
3. The obligation of the school to help assure optimum health for each individual;
4. The obligation of the school to enable young people to make intelligent decisions about personal, family, and community health.

Shared Responsibilities

The health supervision of the school-age child is a shared responsibility rather than an obligation of any one agency. Parents have the *primary* responsibility for the health of children; the personal physician and dentist are the basic resources for health advice and needed care. Official agencies, including the public health department and the school, and voluntary organizations supplement and reinforce the health efforts of the parents and the physician. Certain civic and service groups also have important contributions to make.

It is evident that the so-called school health program is a school program only insofar as certain of its activities are school-centered. Other health program functions are handled by a variety of individuals and

community groups. Therefore the necessity for evolving some mutually acceptable method for coordination of school and community health resources is apparent.

In a democratic society, coordination is a process of voluntarily working together harmoniously and effectively to achieve a common goal. It involves mutual determination of responsibilities, without interference with the integrity or policies of individual agencies. Those concerned decide together how they can best share responsibility for the various facets of a program. Cooperative relationships based on mutual appreciation of one another's capacities and contributions provide the foundation for effective school-community coordination.

Many groups share concern for the health of children through their school experience, although their number and resources vary from one community to another. These include parental, professional, governmental, voluntary, religious, commercial, civic, and service groups. More specifically, the following are examples of these groups:

Parental	Parent-teacher organizations Other parent organizations with specific responsibility for the health of the school-age child
School	Administrators and supervisors Physicians and nurses Health educators and coordinators Dentists and dental hygienists Counselors and psychologists Classroom teachers Mental health specialists Social workers
Other Governmental	Health Department Welfare Department Recreation Department Mental Health Authority Protection agencies
Health Professions (Private Practitioners)	Medical, dental, and allied health professions
Voluntary Health Agencies	Agencies with special concern for the present or future health needs of the school-age child
Commercial, Religious, Civic, Service, and Other Groups	Organizations with a special concern for health and welfare of children and youth

Ideally, all of the groups that make a direct contribution to the health of the school-age child should be involved in the process of coordination. Practically, however, this is difficult to achieve, particularly in larger communities with their complex organizational structure. Although groups and resources will vary within communities, coordination is still essential. Through such teamwork, communities can facilitate the development of a well-rounded school health program.

Definitions

Clarification of terms is important to good communication, which, in turn, is essential to effective coordination. To facilitate communication, definition of terms relating to school health activities is desirable. Commonly accepted definitions for terms pertinent to this document are as follows:

1. **SCHOOL HEALTH PROGRAM**
   The composite of procedures used in school health services, healthful school living, and health science instruction to promote health among students and school personnel.

2. **SCHOOL HEALTH SERVICES**
   The procedures carried out by physicians, nurses, dentists, teachers, and others designed to appraise, protect, and promote optimum health of students and school personnel.

3. **HEALTH INSTRUCTION**
   The organized teaching procedures directed toward developing understandings, attitudes, and practices relating to health and factors affecting health.

4. **HEALTHFUL SCHOOL LIVING**
   The provision of a safe and healthful environment, the organization of a healthful school day, and the establishment of interpersonal relationships favorable to emotional, social, and physical health.

The three commonly accepted elements of the over-all program—school health services, healthful school living, and health science instruction—represent convenient labels for integrated aspects rather than distinct divisions of the school health program. The success of the total program depends upon the interrelated and interdependent functioning of these elements.

Varied Contributions

Any discussion of health program development or operation must take into account the total school-community relationship. The contributions

which community agencies can make and, in some instances, are legally and morally bound to make are extremely varied. These differences stem from the nature of the agencies themselves and from the differences in communities. Community agency contributions may range from consultation on technical matters to general support of the school health program through provision of financial, material, and human resources.

Coordinating the health program, whether within the school or between the school and a community agency or program, necessarily involves people of varying skills and responsibilities. This involvement ranges from informal, personal contacts to complex inter-agency agreements. Coordination efforts may focus on a suspected health need of a single child or may be concerned with bringing about a smooth working relationship among complex programs of several organizations.

Personnel Relationships

Although organizational and administrative patterns can facilitate coordination, teamwork in person-to-person relationships is the most crucial factor in program coordination. The number of persons and the variety of professional disciplines concerned with the health problems of the school and the community point up the importance of coordinated effort. Identification and solution of a single health problem may involve many individuals. Beginning with the student himself, these include teachers, parents, school administrators, guidance counselors, physicians, nurses, health department personnel, dentists, psychologists, social workers, and representatives of voluntary agencies.

To illustrate, a teacher observes that a boy in his class is displaying unusual behavior. To confirm his observation, the teacher and nurse discuss the youth's behavior with his other teachers. With the aid of the principal, a conference with parents is scheduled and results in the decision to refer the youth to the family physician. Upon medical examination, it becomes apparent that certain specialized services are necessary. Follow-through involves not only treatment but also a careful plan for rehabilitation. This will necessitate altering some of the boy's routines at home and school to achieve the most satisfactory recovery and adjustment. Should the cost of the services be beyond the family's resources, other individuals and community agencies will be involved.

This example gives some indication of the complexity of individual and group interactions in health matters. The importance of teamwork is apparent when one considers that each such interaction is a possible stumbling block in progress toward a successful outcome.

School-Community Relationships

The organization and administration of school health programs vary greatly with the extent and nature of services provided. While boards of education usually have the major responsibility for determining and operating the in-school aspects, many community agencies are involved in providing services and personnel for the total program.

Some schools employ their own nursing personnel and, in larger communities, may have their own medical staff as well. In such instances, the school's part of the program is independently operated but definitely related to other community health programs. In other situations, the public health department provides personnel and services either through its own budget for the purpose or on a contract basis with the schools. In still other instances, arrangements to provide services are worked out with local medical societies or private physicians. Voluntary health agencies sometimes provide schools with certain services and personnel.

The school health service program in the United States is predicated on the principle that the family has primary responsibility for the health of the school-age child. School health services include health appraisals, health counseling, communicable disease control, encouragement of the correction of remediable defects, program adjustments for handicapped children, and emergency care which is limited to first aid arising from accidents and sudden illness.

Fundamental to the coordination of the school-community program is recognition of these limitations on the services which schools provide. Especially important is the realization that the local health officer is charged by law with the provision of certain basic services for the total community. Also, since health services are rendered in a variety of ways, each community must be studied in light of its human and material resources to determine the most appropriate delineation of responsibilities.

Adequate follow-up of the health problems discovered through the school appraisal is dependent upon a coordinated working relationship among the parents, the school, and other community agencies. Coordination of school-community programs helps to facilitate appropriate referral of problems, allows more accurate assessment of community health needs and resources, helps to eliminate duplication of services, promotes more effective use of existing services, and can lead to filling gaps in available resources.

Coordination relating to program planning can be illustrated by reviewing a typical school health activity such as promotion of the periodic medical examination. Community involvement is essential if desired outcomes are to be realized. Since arrangements for the examina-

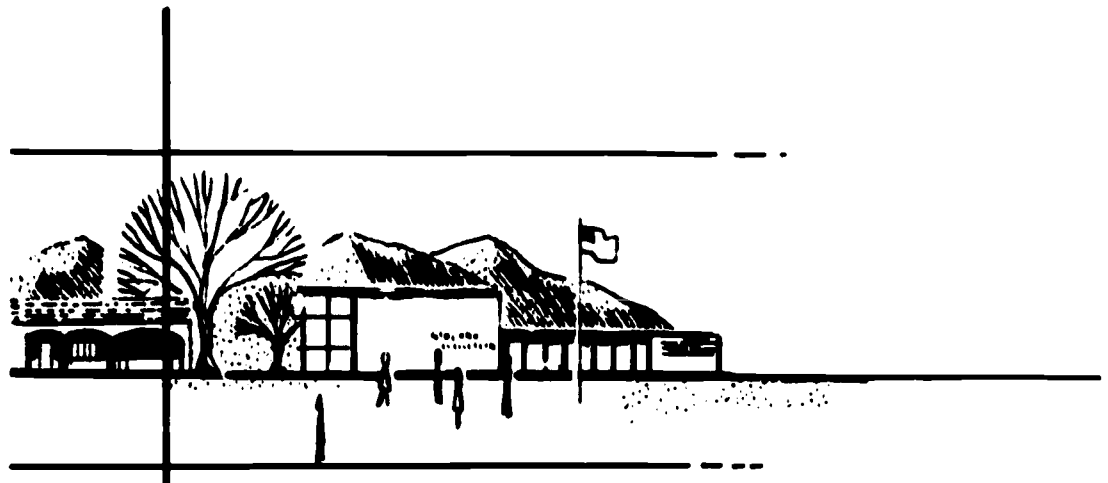
tion are a family responsibility, purposes and values of the health examination must be properly interpreted to pupils and parents. School officials will need to counsel with representatives of the local medical society to determine such things as the general policies governing examinations, items to be included, locale and frequency, and procedures for recording and reporting findings. Development of a plan for examining those children who do not have a family physician illustrates still another need for harmonious working relationships among the school, the parents, and community health and welfare agencies.

The follow-up and correction or adjustment of pupil health problems revealed through the periodic examination and other appraisal procedures call for excellent communication and cooperation among the school, the family, private practitioners, and community agencies. Each has also a highly individualistic role to play. This phase of the program provides a tangible example of how coordination of school community health functions helps to assure the fullest utilization of available health services and resources.

Intra-program Coordination

Health education, health services, and healthful school living are the interrelated and interacting parts of the total school health program. Their integration requires fine coordination for optimum values in health education and health promotion. For example, the health problems identified through school health services can become important elements in the health education curriculum. Similarly, health education helps build understanding and appreciation for such health service activities as the periodic medical examination, immunization, dental care, and follow-up procedures. Healthful living at school at optimal physical, emotional, and social levels provides the essential conditions for services and reinforces health learnings. Careful coordination of services provided by pupil personnel and by the school health program is needed to avoid fragmentation and duplication of services.

In addition to coordination among elements of the school program, there is need for coordination of activities within these elements. In health education, planning of the scope of each grade level and sequence from grade to grade is particularly important. There should also be articulation between elementary and junior and senior high school programs as well as coordination of the health instruction offered through related courses. Health services need careful scheduling at opportune times in the lives of young people and in terms of the total school program. The mental-emotional-social aspects of living at school need to be properly related to the physical environment.



PATTERNS FOR COORDINATION

The distinction among the common approaches to coordination is not always clear-cut, but in general these approaches may be classified as: 1. Informal procedures; 2. The ad-hoc problem-solving group; 3. The continuing committee or council; 4. The specialized advisory committee; 5. Combinations or adaptions of the foregoing. Each of these devices or methods has inherent strengths as well as certain limitations.

Whether one pattern or another will work best in a given situation depends on a variety of factors. Among these are: the kind of personnel concerned, the type of leadership available, the relationships among individuals and groups, the customs and traditions in the community, and the nature of the problems involved.

Informal Procedure

An informal approach to coordination does not imply an unplanned or unorganized process. The informality exists only because no formal machinery such as a committee or council is employed. Those who need to communicate with each other utilize their day-by-day contacts for this purpose. Or, if need be, they make the contact by telephone, by visitation, or at some community event where those concerned are present.

Thus, the superintendent of schools may bring a pertinent school health problem to the attention of the community health officer at the weekly meeting of the service club. The health officer, in turn, may confer with the chairman of the school health committee of the local medical society at the next meeting of that organization. Then after discussing the problem with the nurse serving the school, and perhaps with other members of the staff, the health officer may call the superintendent to make suggestions for solution of the problem. In working out solutions, not only official agencies and professional associations but also voluntary organizations and sometimes civic groups may be involved.

In a school with its own medical and nursing service, the pattern is necessarily somewhat different, but basic principles remain essentially the same. The medical director then provides needed medical consultation and liaison for the administrator. Again, contacts are made on a person-to-person basis as problems present themselves. This process may be initiated by the person who first recognized the need, but follow-through proceeds through channels with the designated director, consultant, or supervisor (coordinator) serving as intermediary and facilitator of the person-to-person process.

At first glance, informal approaches may seem to have their best application in smaller communities and for problems of lesser complexity. Under certain conditions, however, informal procedures may be the pattern of choice in larger places and for more difficult problems. Free interchange is ordinarily facilitated in the one-to-one relationship; there is easy opportunity to give and take, and less likelihood of misinterpretating and misunderstanding. Equally important, since the group does not meet together, problems of inter-personal relationships are minimized.

Informal approaches, on the other hand, may waste time and energy and complicate communication. The contacts required are multiplied by the one-to-one aspect of the process, and the mental interactions and synthesis of ideas that occur when people meet in groups are lacking. Whether informal procedures for coordination will be productive in a given community is a matter for local evaluation. Both the merits of the process and the nature of the community should be considered in making this decision.

Ad-Hoc Problem-Solving Group

A second approach to coordination of school health efforts is to activate problem-solving committees as needs are recognized. An ad-hoc (special purpose) committee includes representatives of those faced with the problem and of the disciplines in the school and community likely to be involved in its solution.

Any responsible person or group that recognizes the need can initiate action by bringing the problem to the attention of the appropriate authorities. Ordinarily the committee is first called together by the school administrator, his designate, or the community health officer, depending upon the nature of the problem. Each is responsible for certain facets of the program, according to applicable laws and regulations.

For example, the school administrator may take steps, through his ad-hoc committee, to deal with an educational problem like the development of a new guide for teaching health in the elementary school. Rep-

resentative teachers may be asked to indicate desirable outcomes at the various grade levels and to suggest related learning experiences and instructional resources. Medical and dental representatives might be called upon to check the scientific accuracy and points of emphasis of textbooks, pamphlets, films, and other teaching materials. Community health personnel could contribute information about pertinent local health problems, and parents could supply information on health practices needing home and school attention.

Similarly, the community health officer might activate an ad-hoc committee to be concerned with the problem of communicable disease control, such as how to raise the level of protection against polio among children and youth of school age. Health department personnel might agree to outline and publicize recommended immunization policies. The nurse serving the school might gather information on levels of protection in the community and then indicate problem areas. A physician representative could suggest the most acceptable procedure to provide the greatest number of young people with the needed protection. A teacher on the committee might volunteer to explore educational approaches and motivation, and a parent organization delegate might agree to help develop plans to encourage appropriate family responsibility for immunization.

Other individuals and groups can contribute significantly to the solution of these and other problems. Voluntary health organizations and certain civic and social agencies have both human and material resources that may be helpful. The test of the need for the involvement of a given agency in the efforts of an ad-hoc committee is in the closeness of the group's relationship to the problem under consideration. How closely do the goals and activities of the group relate to this particular problem? Would its resources be of material help in arriving at a solution? If the help of a given agency is needed to solve a problem, the group should share in reaching the solution.

The ad-hoc committee offers certain important advantages as a device to facilitate coordination. Compared to informal procedures, it saves time and energy by bringing together, at one time and in one place, all those who can contribute to solving a problem. It is more efficient than continuing groups in that only those directly concerned need to be involved. There is value, too, at times in the fact that, when its task is completed, it can be dissolved and a fresh start made.

The ad-hoc committee, nevertheless, has limitations as a coordinating device. Bringing together divergent personalities or disciplines sometimes creates problems that impede progress. Continuity is more difficult to maintain than in a continuing group and morale may not be as high.

Also, in their concern over a specific or limited problem, committee members may fail to visualize the school health program as a whole.

Continuing Committee or Council

The school health committee or council has long been a suggested method of facilitating understanding and cooperation among those interested in developing and improving the school health program. The committee is usually defined as a coordinating group made up largely of staff within a single school. Sometimes key individuals from the neighborhood served by the school are included to reflect the interests of the community.

The council, in contrast, is a more broadly based organization serving a school system, district, or county as a coordinating group. Membership includes representatives from the schools and from a variety of community agencies contributing to child health. Such a council involves the official health agencies, the local medical and dental societies, the voluntary health organizations, and certain civic and service groups; it may also include student body representatives. The groups that may be involved, depending upon local circumstances, are listed on page 2.

The basic obligation for the health of children belongs to the home; parenthood imposes both moral and legal health responsibilities upon the marriage partners. The administration and staff of the school and health agencies are charged by law with certain reinforcing functions. Also, like other community organizations, the official agencies feel a moral responsibility to encourage parents to carry out their obligations and to supplement the health efforts of the home whenever necessary.

This structure of legal and moral responsibility makes it clear that a school health council, committee, or other coordinating service operates only in an advisory role. Policy-making resides in the legally constituted boards governing schools and health departments. However, workable policies are developed with consideration for available health resources and in terms of procedures that are educationally desirable, medically acceptable, and in keeping with recommended public health practices. Thus, in its advisory role, the school health council or committee can serve a valuable policy-suggesting function.

The school health committee in an individual school is concerned with problems relating to health instruction, healthful school living, and health services for that particular school. Often a major function is the task of adapting the flexible policies of a school system or district to the needs of the individual school. Specifics necessarily differ, from one school to another, in terms of the manpower available, the socio-

economic status of the area, the condition of the building and its environs, the facilities and equipment provided, and the customs and traditions of the school community. A close working-relationship between the health committee in the individual school and the system-wide council is mutually advantageous.

Meeting periodically or on call, the council provides an orderly procedure for mobilizing community health resources to assist those legally responsible for protecting and promoting the health of school-age children and youth. The broad concerns of the council may include:

1. Delineation of the various aspects of the school health program;
2. Interpretation of these functions to member agencies and the public;
3. Definition of the health responsibilities of the school and other community agencies;
4. Determination of local school health strengths and needs;
5. Identification of resources to meet recognized needs;
6. Recommendations of related policies and programs;
7. Evaluation of progress made and detection of unmet needs;
8. Initiation of follow-up projects and programs.

A continuing council is not an operating organization; to become such would be to usurp the prerogatives of its member agencies. Rather, the council helps to relate identified problems or agreed-upon projects to the member agencies best equipped to implement them. In serving this function, the council seeks always to assure optimum use of available resources before suggesting the provision of new facilities or programs. Where the need for new services is demonstrated, the council can aid in interpreting the need and favorably influencing public opinion. In its coordinating role, it can also help to assure the proper relationship of new resources to existing services and facilities.

With a desire to achieve broad representation of the agencies concerned, school health councils have sometimes become too large and unwieldy for effective work. One possible solution is to have a central core or steering committee, which meets more often than the larger group, to formulate plans and agenda for action. Another is to limit membership by asking each category of agencies, such as the voluntary health agencies, to select one mutually acceptable representative, perhaps on a rotating basis. A third possibility is to confine continuing membership to representation from a small group of the most directly concerned agencies, with others being invited to participate temporarily when their interests are involved.

When a large council is advisable, some form of subcommittee organizations seems imperative. Subcommittees not only help in terms of more efficient action on specific problems but also provide a focus of

common interest for various segments of the membership. A cross-section of the various disciplines is often desirable on subcommittees, but for certain problems a group of specialists may yield the best results. Subcommittees, serving the council as study groups, report back periodically to the larger group. Decisions and policy recommendations are matters for the council as a whole.

The continuing committee or council has certain obvious strengths as a coordinating mechanism. These apply equally well for either the individual school health committee or the system-wide council. Greater continuity of effort is possible with a continuing group than with either the informal approach or the use of ad-hoc committees. More important, a continuing council brings to the school health program support that can be gained in no other way. Its role in interpreting and marshaling support for an effective school health program can be fully as important as its advisory function.

Unless the functions of the committee or council are well-defined, however, the school health program may be impeded rather than advanced. When a council departs from its rightful advisory role or intrudes into provision of services, it can be more disruptive than helpful. When it becomes a mechanism for agency advancement or a device for agency promotion, it defeats its own purpose. Yet none of these weaknesses are defects in the council approach but rather are perversions of its purposes and goals. The effectiveness of a school health committee or council is dependent on the integrity of its members and the ideals they hold for children and youth.

Specialized Advisory Committees

Special competencies are needed in the process of making intelligent decisions about many aspects of the school health program. For example, what procedures for screening hearing best meet the needs of the local situation? Or how often, if at all, should dental examinations be given at school? In the first instance, the medical society might be invited to appoint a committee to make recommendations; in the second, the dental society might be called upon for help. Technical help is needed on a variety of special problems and functions relating to both health services and environmental controls. In such cases, the specialized advisory committee provides an invaluable service.

Frequently, competencies in more than one field may be desirable within the membership of a specialized advisory committee. A committee to make recommendations on the matter of medical excuses from physical education would need representation from the school administration as well as from medicine and physical education. A committee

to decide on priorities in the duties of the nurse serving the school should have representation from the field of public health as well as from the school administration and the nurse's group itself. It is advisable, in general, to include representation from each of the disciplines directly concerned with a problem. Those less directly involved can be brought in on a consultative basis, when the need becomes apparent.

The specialized advisory committee is essentially a study committee and, as such, may be a subcommittee of the school health council or committee or even of an ad-hoc committee. Or it may be an entirely separate committee established, on a continuing or temporary basis, to deal with a specific problem or area of the school health program. The specialized advisory committee operates best when its responsibilities are clearly defined. Generally its task involves a four-point approach:

1. Study of the existing program or situation in the area of its concern;
2. Review of authoritative recommendations relating to the matter under consideration;
3. Identification of the strengths and limitations of the present program or situation;
4. Recommendations for action in terms of local needs and conditions.

Specialized advisory committees, appointed and discharged according to need, provide a means of relating the school health program to community agencies concerned with child health. At the same time, when properly constituted, they are a source of the technical advice needed by the school staff. Such a system can be cumbersome, however. Without careful planning, it is difficult to maintain cohesion among the various committees and facets of the program. Unless specialized advisory committees are related to an over-all coordinating group, it is doubtful whether they can bring the support to the school health program that a continuing larger group can muster. Advisory committees make a special contribution on pertinent problems but are not generally regarded as a substitute for an over-all coordinating group.

Adaptive or Combination Procedures

A variety of adaptations and combinations of the foregoing procedures for coordination are possible. Mentioned earlier was the committee or council operating with subcommittees which may be either ad-hoc (limited purpose) groups or specialized committees concerned with technical subjects. The informal approach is often evident where councils and committees function smoothly. In such situations, a key person or persons may function as "facilitators" to implement teamwork. Often, without official designation, they perform the liaison services so essential to any kind of effective community relations.

Another common adaptation is the situation in which the school health council is a subcommittee or constituent part of an over-all community coordinating council. Not all community coordinating groups lend themselves to this arrangement; however, where the type of organization and the community climate make it possible, such a relationship is certainly desirable. Otherwise, the school health council will usually duplicate much of the membership as well as the goals and purposes of the larger group. Where there is a community health council, the same principle has equal validity, and a close working-relationship—if not an affiliated status—is essential.

General Guidelines for Coordination

Through experience, a few general principles to help coordinating groups function effectively have become apparent. These have general application regardless of organizational details:

1. *A problem is needed.* Every school has health problems although they are not always recognized. Working on a tangible problem helps to get a group moving.
2. *Start with a simple problem.* This will encourage growth in a group's ability to work together. Gradually more difficult problems can be attacked.
3. *Keep within reasonable size.* Too large a group may become unwieldy and ineffective. When size is essential, work through subcommittees.
4. *Organize along simple lines.* Be sure real goals or problems are not lost in a clutter of parliamentary procedure.
5. *Involve official representatives.* Good fellows are fine, but only an individual appointed by his agency or professional group can really represent his organization.
6. *Analyze the job.* Decide what needs to be done and how available resources can best be applied to the task.
7. *Stay out of operations.* A coordinating group does not provide direct health services. A departure from this principle creates discord and dissension.
8. *A spark plug is needed.* In the background of every successful coordinating plan, there is a good detail person. Someone is needed to handle mechanics, often with little or no recognition.
9. *Meet according to need.* Hold meetings only when there is real work to be done. There is an advantage in definite dates, but proper spacing for the job is vital.
10. *Leadership is essential.* A chairman who can hold the group together and stimulate members to unselfish action is the key to effective coordination.

LEADERSHIP THAT PROMOTES COORDINATION

Effective coordination among the people and agencies involved in the school health program is dependent upon strong and mature leadership. Such leadership requires understanding of the school health program, appreciation of program goals, skill in working with people, and a discriminating use of authority. It also requires knowledge of the community structure and mores and adaptability to meet the needs of particular people and specific situations.

These attributes, common to all forms and levels of leadership, are particularly important in cooperative endeavor, involving the coordination of both human and material resources. The test of good leadership is found in the quality of the coordination achieved—the active participation of those who need to be involved, the absence of gaps and overlapping, and the capacity to carry the cooperative task to a successful completion.

Leadership emerges as a result of group needs and the nature of the activity. It is specific to a situation. The one who becomes a leader in any given instance is determined by the issues of the moment.

Leadership is not an isolated concept. Although it may be exerted by one group member, it can be shared by each individual. The test of effective leadership is in the degree to which members participate in the process of making decisions.

Leadership that promotes coordination of school-community health activities is characterized by certain attitudes and patterns of action. Among these, the following are basic:

1. Greater value is placed upon coordination than upon conformity to prescribed patterns.
2. Members of the group make unique contributions which merge into productive teamwork to achieve health and education goals for children and youth.

3. Achievement and the accompanying satisfaction are shared by many people; leaders react favorably to both the individual and collective accomplishments of those involved.
4. Helpful leadership is alert to the total needs of children and the interdependent interaction of the child and his family in the school and community.
5. Leadership is related to definite goals that are carefully formulated, periodically clarified, and continuously evaluated.
6. The integrity of individuals, groups, and agencies is maintained as progress toward established goals is made.
7. Contributions of all persons directly associated with the program under development are profitably utilized.
8. Leadership tends to be specific to particular situations; differing individuals assume the leader's role, depending upon the personnel involved and the nature of the problem.
9. There is understanding and appreciation of the organizational structure areas of operation and accepted functions of each of the agencies involved.
10. Good leadership knows where to find needed help and demonstrates ability to marshal and utilize available resources.

Responsibility for Leadership

Effective coordination of community-school health activities is dependent upon successful leadership at several levels. At one extreme, the leadership may be concerned with such simple matters as arrangements for meetings. At another, it may involve a number of individuals who accept responsibility for leading the group toward accomplishment of some complex task. At still another level, the administrative heads of official groups may make decisions on broad policy matters.

Effective leadership requires appropriate delegation of responsibility, assurance of administrative support, and provision of the necessary authority for action. Delineation or definition of responsibility is also an important aspect of leadership. Those to whom leadership is delegated must know their areas of responsibility and understand the limitations of their authority. Such definitions must be keyed to the qualifications of personnel and adjusted to the needs of the program.

Another major responsibility of leadership is that of initiating coordination as a continuous and on-going process. This includes developing with the responsible parties—the parents, practicing physicians, dentists, school personnel, health department workers, and others—the concept of joint planning and action. Administrative and staff personnel must be in reasonable accord, or cooperative endeavor will be hampered.

Appropriate orientation of top-level administration, including those

from the school, the health department, and other agencies involved, is also a responsibility of leadership. This is true both during the beginning stages and in the continuing process of coordination. Accomplishment of such orientation often depends upon a clear understanding and constructive use of the various forces to which administrations are responsive. For example, parents may be particularly influential with the school, voluntary agencies may respond readily to suggestions from the educator, and health department personnel may be sensitive to considerations submitted by the local medical society.

Other priority concerns of leadership include a sensitivity to areas of duplication and gaps in function and practice, within programs and among contributing agencies. Equally important is the matter of developing effective means of communication between health and educational personnel, between schools and parents, other community agencies and schools, parents and professional workers, and among the many different people with special capacities and resources of service to children and youth. Effective communication depends, first, upon general understanding of the need for clear communication and, second, upon the use of a variety of practicable communication techniques.

Understanding and support from groups other than the official agencies are always desirable, irrespective of the developmental level of the school health program. There are many instances in which nonofficial agencies have initiated, piloted, or otherwise made possible the development of well-coordinated programs. While these groups have not always received appropriate recognition for this leadership, the history of school health is replete with examples of how the official agencies have benefited from such efforts.

Great skill and diplomacy are required of nonofficial personnel who work with administrators and staff more substantially related to the school health program. This is particularly true when school officials give the program little attention and fail to exercise a proper leadership role. Sometimes a nonofficial agency can change this situation by evidencing concern and stimulating interest within the official agencies. In some instances the interested agency needs only to assist in recognition of a school health problem and to suggest approaches to its solution.

The appropriate role of nonofficial groups in school health activities is ordinarily one of initiation and demonstration. Once the feasibility and value of an activity have been established, the nonofficial group should relinquish gradually the general leadership function. Following the pilot period, the appropriate official agency should rightfully accept the responsibility.

Delegation of Authority

The breadth, depth, and complexity of school and community health and education necessitate delegation of authority and placement of responsibility for the various facets of the program. Discriminating delegation of authority not only increases the potential for program development but also conserves the time of key administrators while encouraging improvement of the leadership capacities of others.

Delegation of authority for policy development and program operation does not relieve top administrators of over-all leadership responsibilities. They retain the obligation to provide continuing support and essential counseling as well as to encourage periodic evaluation. In this framework, top administrators share appropriately with delegated leaders in both on-going efforts and resultant successes and failures.

Just how school health responsibilities should be allocated is a matter that must be worked out in each particular situation. Certainly the decision should be preceded by determination of such things as legal responsibilities, special needs of the school-community situation, availability of personnel, and the time schedule and energy level of persons to whom responsibility is to be delegated.

Delegated authority should be entrusted only to those individuals with personal and professional qualifications commensurate with the degree of responsibility involved. The appointment of a "leader"—director, coordinator, or consultant—by no means assures the ultimate achievement of the inherent objectives of the program. In general, leadership will find it wise to delay such designation until those concerned can thoroughly assess the situation and until the right person can be found or perhaps be prepared for the assignment.

Determination of which responsibilities should be delegated is also peculiar to each school-community situation. Some of the factors involved include the nature of the activities, number of persons concerned, established relations and channels of communication, and the patterns of school-community planning and action in general. Irrespective of these factors, the general administrator cannot be encumbered with mechanical detail without interfering with his broader leadership functions.

Administrative Support

High-level leadership has the function of assuring a climate for coordination in which leadership is fostered among those to whom responsibility has been delegated. It further has the obligation of encouraging leaders responsible for various parts of the program to work together toward common goals.

When responsibilities are assigned to an individual, this presupposes the confidence and the support of the delegating authority. Effective coordination requires, however, that all other personnel understand that such support is definite and not merely implied. The most helpful support relates primarily to goals and accomplishments and less directly to the individuals concerned.

Good administration, nevertheless, gives recognition to individual as well as group accomplishments and lends encouragement by expressing appreciation for progress being made. This is possible, however, only if those with delegated leadership responsibility keep administrative officers informed and accurately interpret progress and accomplishments.

Another kind of support relates to the provision of necessary facilities, supplies, budget, time, and freedom of action commensurate with the responsibility of a particular assignment. Effective leadership recognizes the importance of both the tangible and intangible factors in the satisfactory achievement of assigned responsibilities.

Local Determination of Responsibility

Determination of responsibilities for leadership in the various facets of a program and allocation of the necessary authority must be determined in the light of local circumstances. Patterns and procedures that are appropriate and effective in one setting may not be applicable or even adaptable in another situation. There are differences among states, communities, and school and health jurisdictions that necessitate varying approaches and decisions. These include local variations in:

1. Health and education needs, and resources to meet them;
2. Socio-economic status, sources of financial support and the funding mechanism;
3. Availability of professional and auxiliary personnel;
4. Cultural patterns and ethnic influences;
5. Legal requirements impinging on the health and education agencies;
6. Leadership capacities of available personnel;
7. The formal and informal power structures involved;
8. The underlying philosophy of programs for children and youth.

In addition to the differences which occur from one state to another, from community to community, and school to school, there are also other forces at work which necessitate different program directions and dimensions. Among the many factors which raise implications for almost every aspect of health and education are the following:

1. Changing philosophies of education, curriculum, and community health practices;

2. New technical and scientific developments;
3. Advances in all areas of health and education;
4. Sociological changes, such as the increasing number of children in the family, working mothers, and youth in college;
5. The growing population mobility;
6. New developments in the design, construction, and maintenance of school buildings.

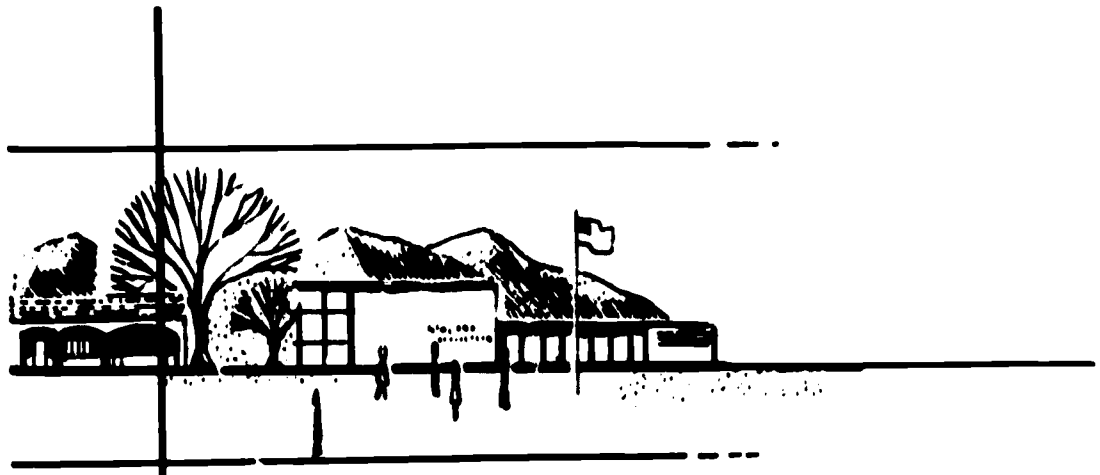
These societal variations and their everchanging influences make it mandatory that leadership personnel, at all levels and in all groups concerned, continually evaluate their coordination practices to be sure that they are consistent with present needs and current trends. The quest for new leadership resources to meet the multiple tasks facing health and education is a major challenge for school health personnel.

In attempting to coordinate the school health program, it is important to understand the role of the "leg worker" (who may or may not be the nominal leader) in the mechanical phases of coordination.

Basic to any effective coordinating plan is the efficient handling of the numerous details involved in convening representative people for meetings or conferences on problems and programs of mutual concern. Arranging for effective communication when the people concerned do not meet together may involve even more detail. Included among the mechanical tasks are:

1. Scheduling conferences and meetings;
2. Arranging for appropriate facilities;
3. Sending out notices, reports, and announcements;
4. Providing such things as chalk boards, loud speakers, chairs, and refreshments;
5. Recording proceedings, duplicating and distributing agenda and attachments;
6. Arranging for consultants, needed transportation, stenographic help;
7. Preparing and duplicating minutes, operating codes, records.

The kind of person who may be able to supply this much needed "leg work" will vary with the local situation. Essential tasks may have to be performed initially by several different people with the help of a coordinator. These may be staff members, clerical personnel, or volunteer workers. More important than their category is the calibre of their interest and their willingness to work. The responsibilities of each individual should be delineated, with one person assigned as over-all coordinator for mechanical details. It will also be helpful to spell out details in writing, including step-by-step procedures, individual responsibilities, and time of execution.



PRINCIPLES OF COORDINATION AND EVALUATION

The school's concern about health problems of children may involve selection of methods to resolve these problems either as an individual agency or in cooperation with others. In either case, it is important that the methods chosen be in accord with established patterns of community action and interaction. Customs and traditions, as well as the availability of personnel and facilities, are involved.

The fact that children have certain unmet health needs does not necessarily mandate the school to meet these needs. In many instances, the school may be better advised to initiate community action which results in the assumption of responsibility by a more appropriate agency. In most instances, the school's role is one of recognition and referral rather than direct action.

When the school administrator does not feel that the school should assume responsibility, then individual parents, the official health agencies, voluntary associations, or professional groups—depending upon the nature of the problem—may appropriately assist in the development of a coordinated program. The basic goal should be improvement of health for school-age children through the most effective use of available resources.

Basic Principles

Coordinating groups need to develop procedures through which each member agency can gain an understanding of the true functions of all represented agencies. This requires a plan by which the interests of all groups concerned with child health can be carefully considered and definitely delineated.

If effective working relationships are to be established, there must be a feeling of mutual respect for the skills and abilities of each of the dis-

ciplines involved. This can only exist when there is a shared appreciation of the unique contributions that various types of health and education personnel can make to the welfare of children.

Effective coordination requires, first of all, a general awareness of all the health resources, human and material, that are available within a given community. A careful inventory of such resources is a basic task of any coordinating body or facility that may be established. Also involved is a continuing review of resources so that all concerned will be thoroughly familiar with what is available.

Coordination has a broad and varied perspective. There needs to be a plan for coordination within the individual school, among the schools in a school system, and between the school system and community agencies. Also, there should be an awareness of service obtainable from state and national agencies.

Members of coordinating bodies have the obligation of presenting the viewpoint of their agency to the group while constructively contributing to joint planning. Also, they have the responsibility of interpreting and reporting the consensus and actions of the coordinating group to the agencies they represent. To carry out these functions effectively, it is essential that they be official appointees of their agencies.

To assure orderly direction and continuity of program, responsibility for implementing coordination efforts should be delegated to a properly qualified person. A staff person is usually charged with this responsibility. There may be situations, however, in which other members of the coordinating group assume this function with constructive outcomes for the school health program.

Important to the success of a coordinating body is the initial concern of the group with problems that are not too controversial, that have a good chance of being solved, and that can be resolved in a relatively short time. As the members of a coordinating body gain experience in working with each other on less difficult problems, they become better prepared to deal with more complex and controversial issues.

Most community agencies are specifically oriented. The school, for example, is educationally oriented. The health department and voluntary health agencies are health-oriented. Health promotion, although an important objective of the school, is but one of a number of goals. On the other hand, health improvement is the primary purpose of public and private health agencies.

Many health agencies have specific objectives to which they are dedicated and for which they feel a particular obligation. Usually they have personnel with special skills and abilities relating to these areas of specific interest. By pooling these resources with other agencies having

special competencies in other areas, all can contribute to the total health of the child above and beyond special-interest areas.

For this reason, voluntary agencies are increasingly more likely to view their own areas of interest in the perspective of the over-all health needs of the community. Accordingly, their most recent cooperative endeavors reflect a growing respect for community patterns of action and the policies of the school or other agency charged with responsibility for the specific program when developed.

Each health agency has policies formulated in relation to its basic goals and interests. The practices of an agency, within a cooperative endeavor, must of necessity be limited by these policies. Within such limitations, however, flexibility of an interpretation permits an optimum contribution to general health goals. Frequently, such generalized approaches advance an agency's specific purposes beyond what might be achieved by more direct action.

Mutual Understanding Is Essential

A coordinating body does not fix policy or define program for individual member agencies but rather serves as a "sounding board" and recommending group. Its chief function is to counsel and advise the administrator on the development of school health policies and the solution of school health problems. The advisory group may also suggest practices with recommended policies and program.

The individual representing an agency or organization within a coordinating group is a party only to recommendation for action. Commitment to action is the inherent prerogative of each member agency. To become a policy or part of a program for a given group, a recommendation must be endorsed in accord with usual ratification procedures for that agency.

Each member of the coordinating body needs to understand the procedures by which other member agencies ratify action and to what extent ratified action may be accepted by individual members of a given group or agency. Rarely does a ratified action receive the unqualified support of all of the members of an agency or association.

Cautions in Coordination

A number of inadequacies may contribute to the failure of coordination efforts. Being alert to these obstacles frequently helps to avoid them. Among the most common deficiencies are the following:

1. Failure of the school administrator to authorize someone to execute accepted policies;

2. Lack of understanding (by some individuals and groups) of the total needs of children;
3. Fear of losing agency identity;
4. Failure to recognize that conditions in the school strongly influence child health;
5. Lack of appreciation of the special skills and unique roles of parents, of participating agencies, and of the institutions concerned;
6. Failure to understand that policies and programs agreed upon by a coordinating body lose their effectiveness unless they are workable and acceptable to the school administration.

A coordinating group should develop a plan by which responsible individuals follow through on actions of the body. This implies that there will need to be continuing evaluation of the application of the coordinating body's recommendations. This, in turn, constitutes an evaluation of over-all coordination efforts.

An agency which has been invited to provide representation for membership of a coordinating group should select individuals not only for their knowledge of child health but also for their understanding of and skill in the group process. These competencies are as important as technical knowledge in determining the eventual success of a coordinating group.

The degree of success achieved by a coordinating body is directly related to the degree of interest and concern that administrators of represented agencies display in the deliberations and actions of the coordinating body. The enthusiasm of representatives and their interpretive efforts can have much to do with the administrator's involvement.

Measuring the Success of Coordination Efforts

A number of general principles of evaluation may be applied in checking the effectiveness of coordination efforts. Evaluation can be approached from three viewpoints, as suggested in the following check list:

EVALUATION OF COORDINATED EFFORT IN TERMS OF THE EFFECTIVENESS OF THE PROCESS

..... Is evaluation a continuing process of checking program outcomes?

..... Is there a periodical accounting or summing up of progress made?

..... Are qualitative as well as quantitative measures employed?

..... Are members of the coordinating body involved in the evaluation process?

..... Is growth in the quality of teamwork for achieving specific goals appraised?

..... Is there consideration of desirable changes in goals and purposes as well as in policies and practices?

..... Is evaluation of the effectiveness of the coordinating body related to the projects it has initiated?

..... Is simplicity stressed both in the techniques used and in the design of evaluation?

EVALUATION OF COORDINATED EFFORT IN TERMS OF THE GROWTH IN ATTITUDE AND UNDERSTANDING

..... Have school administrators and teachers demonstrated an increased interest in health?

..... Have parents and pupils become more aware of their own health obligations?

..... Do other community agencies have a better understanding of the over-all school program and the place of health in the total task of the school?

..... Are recommendations of the coordinating body accepted by policy-makers and others affected by the program?

..... Are individuals and agencies who are involved in coordination enthusiastic about the enterprise?

..... Is there improved appreciation of the aims and values of the school health program among professional health personnel?

..... Do school authorities recognize the contributions that can be made by voluntary and professional health agencies?

..... Have the contributing roles of the represented agencies been delineated in writing and are these thoroughly understood and appreciated by member groups?

EVALUATION OF COORDINATED EFFORT IN TERMS OF THE ACTION THAT RESULTS

..... Is there concrete evidence that health needs of school-age children are being met?

..... How well are parents following through in meeting health needs of children?

..... Do school personnel seek the help of community health personnel in developing instructional programs?

..... Do community health personnel respond effectively when called upon for appropriate assistance?

..... Are changes or shifts of emphasis in the health efforts of the official voluntary and professional agencies related to the coordinating effort?

..... Have other problems of community living been resolved by coordinated effort as a result of experiences gained in efforts to coordinate child health activities?

..... **Is there evidence of continued progress in improving the health of children and youth which will enable them to achieve their highest level of potential in all aspects of life?**

Evaluation of coordination efforts is a long-term process because the results of projects and programs that are initiated may not be realized for months or even years. Also, because of the many variables involved, objectivity is a problem, and it is difficult to relate coordination efforts to apparent advances.

Continuing evaluation, nevertheless, gives important clues to the success of the coordination effort. Although indicated gains may not be directly attributable to better coordination, knowledge of progress encourages further cooperative endeavor. The eventual measure of the success of coordination is whether there are improved opportunities for healthy growth and development for children and youth. This, after all, is the only justification for seeking to develop coordination among the several disciplines and groups in a community.

REFERENCES

The following references have been selected from the vast quantity of literature pertinent to teamwork for school-community health programs. Persons interested in delving deeper should also consult their official and voluntary state and local organizations for other resources and materials. Several of the publications (marked *) are out of print or in short supply. They are included because of their continuing usefulness and availability in many libraries.

REFERENCES DEALING WITH GENERAL GROUP DEVELOPMENT, GROUP PROCESS, AND TEAMWORK

ARGYRIS, CHRIS. "Research Trends in Executive Behavior." *Advanced Management* 21:6-9; March 1956.

BENNE, KENNETH. "Case Methods in the Training of Administrators." *Research Reports and Technical Notes*, No. 28. Boston: Boston University Human Relations Center, 1957.

BRADFORD, LELAND P. "The Case of the Hidden Agenda." *Adult Leadership* 1:3-7; September 1952.

REFERENCES

BRADFORD, LELAND P. "A Fundamental of Democracy." *Adult Education* 2:146-49; April 1952.

BRADFORD, LELAND P., editor. *Group Development.* Selected Reading Series One. Washington, D.C.: National Training Laboratories (NEA), 1961. 106 p.

BRADFORD, LELAND P., and others. "How To Diagnose Group Problems." *Adult Leadership* 2:12-19; December 1953.

CARTWRIGHT, DORWIN. *Studies in Social Power.* Ann Arbor, Mich.: University of Michigan Press, 1959. 225 p.

GLIDEWELL, JOHN C. "The Emotional Problems of Group Membership." *Forces in Community Development.* Selected Reading Series Four. (Edited by Dorothy and H. Curtis Mial.) Washington, D.C.: National Training Laboratories (NEA), 1961. p. 39-44.

HARE, P. PAUL, and others. *Small Groups—Studies in Social Interaction.* New York: Alfred Knopf, 1955.

LIPPITT, GORDON. "How To Get Results from a Group." *Office Executive* 3:13-15; January 1955.

LIPPITT, GORDON. "A Study of the Consultation Process." *Journal of Social Issues* 15:43-45; 1959.

LOOMIS, CHARLES P. "Tapping Human Power Lines." *Adult Leadership* 1:12-14; February 1953.

MEZROW, J. D. "Community Development as an Educational Process." *International Review of Community Development,* No. 5, 1960.

MIAL, DOROTHY, and MIAL, H. CURTIS, editors. *Forces in Community Development.* Selected Reading Series Four. Washington, D.C.: National Training Laboratories (NEA), 1961. 106 p.

MIAL, H. CURTIS. *What Is a Consultant?* (Reprint from *Public Relations Journal,* November 1959.)

NYSWANDER, DOROTHY B. "Group Dynamics." *Health Education Monographs,* No. 10. Oakland, Calif.: Society of Public Health Educators, 1961. p. 3-15.

SANDERS, IRWIN. "Theories of Community Development." *Rural Sociology* 23:1-12; March 1958.

SCHMIDT, WARREN, and BUCHANAN, PAUL. *Techniques That Produce Teamwork.* New London, Conn.: Arthur C. Crofts Publications, 1954. 75 p.

SEHNERT, FRANK. "The Community Development Process Within a Procedural Framework." *Adult Leadership* 8:262-64; March 1960.

STENSLAND, PER. "Some Prerequisites for Community Development." *International Review of Community Development,* No. 6, 1960.

THELEN, HERBERT. *Intergroup Conflict; Dynamics of Groups at Work.* Chicago: University of Chicago Press, 1954.

ZANDER, ALVIN, and CARTWRIGHT, DORWIN. *Group Dynamics—Research and Theory.* Second edition. Evanston, Ill.: Row, Peterson and Co., 1960.

REFERENCES DEALING WITH SCHOOL HEALTH PROGRAM AND SCHOOL-COMMUNITY COORDINATION

AMERICAN ASSOCIATION FOR HEALTH, PHYSICAL EDUCATION, AND RECREATION (NEA), HEALTH EDUCATION DIVISION. "How Schools and Voluntary Agencies Can Work Together To Improve School Health Programs." *Journal of Health-Physical Education-Recreation* 26:35-36; October 1955.

AMERICAN MEDICAL ASSOCIATION. "Interrelationships of Health Departments, Departments of Education and Medical Societies in School Health Services." *Report of the Second National Conference on Physicians and Schools.* Chicago: the Association, 1950. p. 34-41.

AMERICAN MEDICAL ASSOCIATION. "Advisory Health Council and the School." *Report of the Fourth National Conference on Physicians and Schools.* Chicago: the Association, 1954. p. 43-47.

AMERICAN MEDICAL ASSOCIATION. "Coordinating Health Records and Examinations." *Report of the Fourth National Conference on Physicians and Schools.* Chicago: the Association, 1954. p. 60-64.

AMERICAN MEDICAL ASSOCIATION. "Interchange of Health Appraising Data on Children." *Report of the Fourth National Conference on Physicians and Schools.* Chicago: the Association, 1954. p. 48-55.

AMERICAN MEDICAL ASSOCIATION. "Medical Society School Health Committee." *Report of the Fourth National Conference on Physicians and Schools.* Chicago: the Association, 1954. p. 56-59.

AMERICAN MEDICAL ASSOCIATION. "Home-School Cooperation." *Report of the Fifth National Conference on Physicians and Schools.* Chicago: the Association, 1956. p. 65+.

AMERICAN MEDICAL ASSOCIATION. "Community Coordination for Youth Fitness." *Report of the Sixth National Conference on Physicians and Schools.* Chicago: the Association, 1958. p. 19+.

AMERICAN MEDICAL ASSOCIATION. "Response—The Voluntary Health Agencies & School Health." *Report of the Eighth National Conference on Physicians and Schools.* Chicago: the Association, 1961. p. 17-23.

AMERICAN PUBLIC HEALTH ASSOCIATION, WESTERN REGIONAL OFFICE, PROGRAM OF CONTINUING EDUCATION. *The Voluntary Health Agency—Meeting Community Needs.* San Francisco: the Association, 1961. 50 p.

•INTERAGENCY CONFERENCE ON SCHOOL HEALTH EDUCATION. *Improving School Health Through Interagency Cooperation.* New York: American Heart Association, 1958.

PATTY, WILLARD. "The School Health Coordinator." *Journal of School Health* 25:336; October 1957.

•SHAFFER, THOMAS E. "School Health Is a Community Undertaking." *Third Ohio Conference on Physicians and Schools.* Columbus, Ohio: Ohio State University, College of Medicine, 1956.

SOCIETY OF STATE DIRECTORS TASK FORCE. *Guidelines for Maximum Effectiveness in School Health Planning by Schools and Voluntary Health Agencies.* Gull Lake, Mich., 1960.

•VAN DER SLICE, DAVID. "Today's Community Concept of School Health." *California's Health.* Vol. 8, No. 9, State Department of Public Health, November 15, 1950.

REFERENCES DEALING WITH LEADERSHIP

BENNE, KENNETH. "Leaders Are Made, Not Born." *Childhood Education* 24: 203-208; January 1948.

BENNIS, WARREN. "Leadership Theory and Administrative Behavior; The Problem of Authority." *Administrative Science Quarterly* 4:259-301; December 1959.

BRAMELD, THEODORE. "Ethics of Leadership." *Adult Leadership* 4:5-8; June 1955.

FRANKLIN, RICHARD. "Training Community Leaders." *International Review of Community Development,* No. 3, 1959.

HAIMAN, FRANKLYN. *Group Leadership and Democratic Action.* Boston: Houghton Mifflin Co., 1951. 309 p.

HERROLD, KENNETH. "Scientific Spotlight on Leadership." *Adult Leadership* 1:11; June 1952.

LINDGREN, HENRY CLAY. *Effective Leadership in Human Relations.* New York: Hermitage House, 1954. 287 p.

LIPPITT, GORDON. "What Do We Know About Leadership?" *NEA Journal* 44: 556-57; December 1955.

LIPPITT, GORDON, editor. *Leadership in Action.* Selected Reading Series Two. Washington, D.C.: National Training Laboratories (NEA), 1961. 96 p.

TANNENBAUN, ROBERT, and SCHMIDT, WARREN. "How To Choose a Leadership Pattern." *Harvard Business Review* 36:95-101; March-April 1958.

WHITE, WILLIAM. *Leadership and Group Participation.* New York State School of Industrial and Labor Relations. Cornell University, Bulletin No. 24, 1953. 49 p.

REFERENCES IN NATIONAL PUBLICATIONS DEALING WITH STATE OR LOCAL HEALTH COUNCILS

AMERICAN DENTAL ASSOCIATION. "Conference on Cooperation in School Dental Health Education." *Journal of the American Dental Association,* Vol. 53, October 1956.

FISHER, CARL C. "Advisory Health Councils Need More Guidance." *Public Health Reports* 69:220-21; February 1954.

HACKENBURG, HERB. "School Health by Citizens' Council." *Journal of School Health* 29:330; November 1959.

KEBRIC, BURT. "The Tulare County School Health Advisory Board Story." *Journal of School Health* 29:164; April 1959.

KELLEY, LEWIS. "Horseheads Central School Health Council." *Journal of School Health* 29:296; October 1959.

KRIGIN, JANE, and GASS, LLOYD. "A Student Health and Safety Council at Clayton Valley School." *Journal of School Health* 29: 67-72; February 1959.

PALMIERI, JOSEPH. "The School Health Council—Is Its Existence Justified?" *Journal of School Health* 29:61-66; February 1959.

U. S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, PUBLIC HEALTH SERVICE. "What's in the Health Council Idea." *Public Health Reports* 67:433+; May 1952.

WALLACE, HELEN, and others. "The Development of a State School Health Council." *Journal of School Health* 31:43-46; February 1961.

GENERAL SCHOOL HEALTH REFERENCES HAVING RELEVANT CHAPTERS OR SECTIONS

AMERICAN ACADEMY OF PEDIATRICS. *School Health Policies; Report of the Committee on School Health.* (Reprint from *Pediatrics,* Vol. 24, No. 4, October 1959.)

AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS. *Health in Schools.* Twentieth Yearbook, Revised edition. Washington, D.C.: the Association (NEA), 1951. Chapter 2, p. 20; Chapter 17, p. 413.

AMERICAN DENTAL ASSOCIATION. *A Dental Health Program for Schools.* Booklet No. S1. Chicago: the Association, 1954. 24 p.

ANDERSON, C. L. *School Health Practice.* Second edition. St. Louis: C. V. Mosby Co., 1960. Chapter 6, p. 101+.

BYRD, OLIVER E. *School Health Sourcebook.* Stanford, Calif.: Stanford University Press, 1957. Chapter 19, p. 311.

COUNCIL OF CHIEF STATE SCHOOL OFFICERS. *Responsibilities of State Departments of Education and Health for School Health Services.* A joint policy statement by the Council and the Association of State and Territorial Health Officers. Revised edition, 1959. 52 p.

GROUT, RUTH E. *Health Teaching in Schools.* Third edition. Philadelphia: W. B. Saunders Co., 1958. Chapter 11, p. 285.

HAAG, JESSIE. *School Health Program.* New York: Henry Holt and Co., 1958. Chapter 18, p. 254; Chapter 31, p. 462; Chapter 32, p. 471.

HARNETT, A. L., and SHAW, J. H. *Effective School Health Education.* New York: Appleton-Century-Crofts, 1959. Chapter 4, p. 59.

IRWIN, LESLIE W., and others. *Methods and Materials in School Health Education.* St. Louis: C. V. Mosby Co., 1956. p. 24.

•KILANDER, H. F. *Health Services in City Schools.* U. S. Department of Health, Education and Welfare, Office of Education, Bulletin 1952, No. 20. Washington, D.C.: Superintendent of Documents, Government Printing Office.

NATIONAL CONFERENCE FOR COOPERATION IN HEALTH EDUCATION, NATIONAL COMMITTEE ON SCHOOL HEALTH POLICIES. *Suggested School Health Policies.* Third edition. Washington, D.C.: National Education Association and American Medical Association, Joint Committee on Health Problems in Education, 1956.

NATIONAL EDUCATION ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION, JOINT COMMITTEE ON HEALTH PROBLEMS IN EDUCATION. *Health Appraisal of School Children.* Third edition. Washington, D.C.: National Education Association, 1961. p. 7, 44.

NATIONAL EDUCATION ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION, JOINT COMMITTEE ON HEALTH PROBLEMS IN EDUCATION. *Health Education.* Fifth edition. Washington, D.C.: National Education Association, 1961. Chapter 1, p. 5; Chapter 11, p. 252.

NATIONAL EDUCATION ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION, JOINT COMMITTEE ON HEALTH PROBLEMS IN EDUCATION. *School Health Services.* Washington, D.C.: National Education Association, 1953. Chapter 15, p. 373.

NEMIR, ALMA. *The School Health Program.* Philadelphia: W. B. Saunders Co., 1959. Chapter 17, p. 229-43.

•NYSWANDER, DOROTHY B. *Solving School Health Problems; The Astoria Demonstration Study.* New York: Commonwealth Fund, 1942. p. 278.

OBERTEUFFER, D. *School Health Education.* Third edition. New York: Harper and Brothers, 1960. Chapter 18, p. 508.

SCHNEIDER, ROBERT E. *Methods and Materials of Health Education.* Philadelphia: W. B. Saunders Co., 1958. Chapter 1, p. 10.

SMITH, H. N., and Wolverton, M. E. *Health Education in the Elementary School.* New York: Ronald Press Co., 1959. Chapter 4, p. 34; Chapter 5, p. 133.

TURNER, C. E., and others. *School Health and Health Education.* Fourth edition. St. Louis: C. V. Mosby Co., 1961. Chapter 3, p. 56; Chapter 4, p. 73.

U. S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE. *School Health Program; An Outline for School and Community.* Public Health Service Publication 834, 1961. (Leaflet)

WALKER, H. *Health in the Elementary School.* New York: Ronald Press Co., 1955. p. 192+.

WILLGOOSE, C. E. *Health Education in the Elementary School.* Philadelphia: W. B. Saunders Co., 1959. Chapter 2, p. 26.

WILLIAMS, J. F., and others. *The Administration of Health Education and Physical Education.* Fifth edition. Philadelphia: W. B. Saunders Co., 1958.

CONFERENCE PARTICIPANTS

George F. Anderson
AAHPER
Washington 6, D. C.

William S. Anderson, M.D.
1901 Wyoming Avenue
Washington, D. C.

Birch E. Bayh
District of Columbia Public Schools
Washington, D. C.

Crescent Bride
Montgomery County Public Schools
Rockville, Maryland

Mrs. Rollin Brown
The National Foundation
New York, New York

Ruth V. Byler
Department of Public Instruction
Hartford, Connecticut

C. Willard Camalier
American Dental Association
Washington 6, D. C.

J. Edgar Caswell
President's Council on Youth Fitness
Washington 25, D. C.

Cecile Conrath
U. S. Public Health Service
Washington 25, D. C.

Marjorie Craig
Metropolitan Life Insurance Company
New York, New York

William H. Creswell, Jr.
AAHPER
Washington 6, D. C.

Roy Davis
U. S. Public Health Service
Washington 25, D. C.

Jeff Farris, Jr.
Arkansas State Board of Health
Little Rock, Arkansas

Edgar Fuller
Chief State School Officers
National Education Association
Washington 6, D. C.

Josephine Gaines
University of Maryland
College Park, Maryland

Claudia Galibier
Montgomery County TB & Heart Association
Kensington, Maryland

Helen Gibbons
National Society for the Prevention of Blindness
New York 19, New York

Marian V. Hamburg
American Heart Association
New York, New York

Morris Hamburg
Principal, Fulton School
Hempstead, New York

Donald Harting, M.D.
U. S. Public Health Service
Washington 25, D. C.

Fred V. Hein
American Medical Association
Chicago 10, Illinois

Harold M. Hobart, M.D.
D. C. Medical Society
Washington, D. C.

William G. Hollister, M.D.
National Institute of Mental Health
Bethesda, Maryland

F. J. Holter
West Virginia University
Morgantown, West Virginia

Howard S. Hoyman
University of Illinois
Champaign, Illinois

James Humphrey
University of Maryland
College Park, Maryland

Harold K. Jack
Temple University
Philadelphia, Pennsylvania

JOSEPH KADISH
National Association for Mental Health
New York, New York

MRS. FRANK KOTTKE
Prince Georges County PTA Council
Upper Marlboro, Maryland

CHARLOTTE LEACH
National Tuberculosis Association
New York, New York

MINNIE L. LYNN
Bouve Boston School
Medford, Massachusetts

GEORGE MCCUNE
Arlington County Schools
Arlington, Virginia

MRS. DWIGHT MCKEOWN
3209 North 19th Road
Arlington, Virginia

SIMON A. MCNEELY
U. S. Office of Education
Washington 25, D. C.

GEORGE MAKSIM, M.D.
1418 Good Hope Road
Washington, D. C.

SPENCER MAPES
American Cancer Society
New York, New York

LEVITTE MENDEL
National Health Council
New York 19, New York

J. J. MILLER
Arlington County Schools
Arlington, Virginia

JOE MOREHEAD
Principal, Williamsburg Junior High School
Arlington, Virginia

WEETA P. MORRIS
Principal, Pine Crest Elem. School
Silver Spring, Maryland

MARY B. RAPPAPORT
State Education Department
Albany 1, New York

J. KEOGH RASH
Indiana University
Bloomington, Indiana

THOMAS E. ROBERSON
U. S. Public Health Service
Washington 25, D. C.

ELSA SCHNEIDER
U. S. Office of Education
Washington 25, D. C.

WILLARD G. SCHUMAKER
Principal, Kensington Junior High School
Kensington, Maryland

JOHN H. SHAW
Syracuse University
Syracuse 10, New York

CARL S. SHULTZ, M.D.
U. S. Public Health Service
Washington 25, D. C.

ELENA M. SLIEPCEVICH
Ohio State University
Columbus 10, Ohio

HARRY STULTS, M.D.
U. S. Public Health Service
Washington 25, D. C.

DAN SULLIVAN
U. S. Public Health Service
Washington 25, D C.

DORIS E. TERRY
University of Maryland
College Park, Maryland

MARY A. THOMPSON
Prince Georges County Board of Education
Upper Marlboro, Maryland

MELEDA THOMPSON
Office of the Superintendent
Archdiocese of New York
New York, New York

DOROTHY C. TIPPLE
State Education Department
Albany, New York

JAMES W. TYLER
Principal, Kenmore Junior High School
Arlington, Virginia

HELEN WALLACE, M.D.
Children's Bureau
Washington 25, D. C.

JAMES WILLIAMS
Principal, Belt Junior High School
Wheaton, Maryland

ROBERT YOHO
State Board of Health
Indianapolis, Indiana

FOR YOUR INFORMATION

Books and pamphlets you may want to read about school health programs and policies

BASIC BOOKS

FIT TO TEACH. Yearbook concerned with the health of the teacher. 1957. Clothbound. 260 p. $3.50. Stock No. 240-06708

HEALTH APPRAISAL OF SCHOOL CHILDREN. Report of Joint Committee of NEA-AMA. 63 p. 70¢. Stock No. 244-06952

HEALTH EDUCATION. Report of Joint Committee of NEA-AMA. Basic text and authoritative reference on school health education. Completely revised 5th ed. 1961. Clothbound. 413 p. $5.00. Stock No. 381-11532

HEALTHFUL SCHOOL LIVING. Guide to a healthful school environment. Joint Committee of NEA-AMA. 1957. 400 p. $5.00. Stock No. 381-11504

PREPARING THE HEALTH TEACHER. Recommendations from five national conferences on professional preparation. 1961. 72 p. $1.50. Stock No. 244-06942

SCHOOL HEALTH SERVICES. Comprehensive guide. Report of Joint Committee of NEA-AMA. 1964. Clothbound. 439 p. $5.00. Stock No. 381-11502

SUGGESTED SCHOOL HEALTH POLICIES. Concise policy statement on school health programs. 3rd ed. 1956. 48 p. 40¢. Stock No. 244-06966

SYNTHESIS OF RESEARCH IN SELECTED AREAS OF HEALTH INSTRUCTION. A publication of the School Health Education Study supported by the Samuel Bronfman Foundation of New York City. 1963. 200 p. $2.00. Stock No. 244-07570

ON SPECIAL TOPICS

ANSWERS TO HEALTH QUESTIONS IN PHYSICAL EDUCATION. Specific recommendations. Joint Committee of NEA-AMA. 1959. 24 p. 50¢. Stock No. 244-06994

AS OTHERS SEE US. For adolescents, on physical appearance, growth, poise, grooming. Joint Committee of NEA-AMA. 1960. 33 p. 25¢. Stock No. 244-06950

SEX EDUCATION SERIES

Parents' Responsibility. For parents of young children of preschool and primary grades. 1962. 47 p. 50¢. Stock No. 244-06852

A Story About You. For students and teachers in grades 4, 5 and 6. 1962. 43 p. 50¢. Stock No. 244-06854

Finding Yourself. For boys and girls of junior high school age and their teachers. 1961. 51 p. 50¢. Stock No. 244-06846

Approaching Adulthood. For young people of high school and college age. 1962. 47 p. 50¢. Stock No. 244-06976

Facts Aren't Enough. For adults working with all age groups from infancy through older youth. 1962. 69 p. 50¢. Stock No. 244-06978

TEACHING DENTAL HEALTH TO ELEMENTARY SCHOOL CHILDREN. For teachers in grades 1-6. Teaching helps and source materials. 1956. 32 p. 75¢. Stock No. 244-06946

TEACHING NUTRITION IN THE ELEMENTARY SCHOOL. Facts and teaching ideas for teachers in grades 1-6. List of sources. 1959. 32 p. 75¢. Stock No. 244-06948

TEACHING SAFETY IN THE ELEMENTARY SCHOOL. Basic teaching suggestions for teachers in grades 1-6. List of sources. 1962. 32 p. 75¢. Stock No. 244-06990

YOUR CHILD'S HEALTH AND FITNESS. For parents and teachers; first appeared in **NEA Journal**, Feb. 1962. 16 p. 35: $1.00. Stock No. 242-06774

YOUR COMMUNITY: SCHOOL-COMMUNITY FITNESS INVENTORY. Checklist to assess school-community programs in health and safety education, physical education, and recreation. 1959. 40 p. 75¢. Stock No. 242-06778

Order from AAHPER, 1201 Sixteenth St., N.W.
Washington, D.C. 20036